## House Bill 1 & Regulatory Misconceptions

1. **Misconception:** The practitioner cannot request a KASPER report unless s/he has the patient's Social Security Number; therefore there are situations where practitioners cannot be in compliance with the recent legislation.

   **Fact:** A KASPER user can request a report by specifying a patient id type of SSN and entering nine zeros, or specifying a patient id type of "other id" and entering a single character such as "0" or "x".

2. **Misconception:** If the practitioner cannot obtain a KASPER report because the system is down or the report shows "manual process", s/he must refuse to prescribe a controlled substance to treat the patient.

   **Fact:** Practitioners should not refuse to treat a patient because they are unable to review a KASPER report. They need to document why they made the controlled substance prescribing decision. If a KASPER report request shows "manual process" the practitioner can document the report request number in the patient's chart. If the KASPER system is unavailable, the practitioner can note the date and time. Should the need arise, KASPER staff can verify when a report requiring manual processing was requested and was made available for practitioner review, or the specific system outage date and time, to confirm the practitioner's effort to query KASPER.

3. **Misconception:** The KASPER system is unreliable and is not available most of the time when practitioners need to use it.

   **Fact:** While KASPER outages have occurred they are not common. KASPER staff members are devoted to correcting the problems that caused the outages, as well as working to improve the KASPER report processing times. The chart below depicts the progress the KASPER technology staff has made in reducing system outages.

| KASPER Uptime Report | | | |
|---|---|---|---|
| | July | August | September |
| Total hours for month | 744 | 744 | 384 |
| Downtime hours | 29 | 11 | 2 |
| Uptime Percentage | 96.1% | 98.5% | 99.5% |

4. **Misconception:** Practitioners must have a signed patient consent form before requesting a KASPER report.

   **Fact:** No patient consent is needed for a provider to request a KASPER report.

5. **Misconception:** A practitioner can place a KASPER report in the patient's medical record, but cannot give the patient a copy of the report.

   **Fact:** A KASPER report can be placed in the patient's medical record, and providers can share the report with the patient.

6. **Misconception:** If a practitioner does not prescribe controlled substances then the practitioner does not need to register with KASPER.

   **Fact:** If a practitioner has a Kentucky Medical License and a valid DEA license the practitioner must register with KASPER to maintain compliance with Licensure Board requirements, regardless of whether the practitioner ever prescribes controlled substance medications.

7. **Misconception:** A practitioner who has a Kentucky Medical License but who only provides patient treatment in a state other than Kentucky is required to run KASPER reports on all Kentucky patients.

   **Fact:** If the practitioner sees Kentucky patients in another state that practitioner should adhere to the requirements of the state where the patients are being treated. The practitioner must register with KASPER as a condition of Kentucky licensure.

8. **Misconception:** If a practitioner runs a KASPER report and the report appears to contain controlled substance dispensing information for his/her patient and another patient; the KASPER is wrong and the practitioner should not prescribe controlled substances.

   **Fact:** There are occasions when the KASPER system cannot distinguish two separate patients and "blends" the information on one report. In these circumstances the practitioner can contact KASPER (502-564-7985) and request a report containing only the information for the correct patient. If the physician cannot obtain a report for the correct patient in a timely fashion, s/he may prescribe as necessary and document the attempt to obtain the information.

9. **Misconception:** A practitioner cannot utilize a KASPER report contained in a patient file and must run a KASPER report every time s/he treats the patient.

   **Fact:** Practitioners need to use their professional judgment to determine if the information in a previously obtained KASPER report is current enough to support their controlled substance prescribing decision.

10. **Misconception:** HB 1 and the Board Regulations prohibit physicians from prescribing controlled substances.

    **Fact:** There is nothing in HB 1 or the Board's regulations that prohibits physicians from prescribing controlled substances.

11. **Misconception:** Physicians are limited to prescribing for only 48 hours worth of controlled substances.

    **Fact:** HB 1 required the Board to promulgate a regulation limiting the DISPENSING of Schedule II Controlled Substances and Schedule III Controlled Substances with hydrocodone to 48 hours. There are no such limits for prescribing.

12. **Misconception:** Physicians must check KASPER each time they write a prescription for a controlled substance.

    **Fact:** HB 1 only requires checking KASPER on the initial prescribing of a Schedule II Controlled Substance or Schedule III Controlled Substances with hydrocodone. The statute also requires KASPER reports to be run once every three months for patients who continue to receive this medication. The Board's regulation follows similar standards; however, it does expand the requirement to include all Schedule IIIs and select Schedule IVs. The Board's regulation does not require a KASPER on the initial prescribing for a Schedule V controlled substance.

13. **Misconception:** The standards promulgated by the Board are brand new.

    **Fact:** The Board has had similar standards, which was set in a Board Opinion, in place for prescribing controlled substances for pain for the past several years.

14. **Misconception:** A physician must obtain a urine drug screen on the initial prescribing of a controlled substance and each time it is prescribed on follow-up.

    **Fact:** The Board's regulations do not require urine drug screens on the initial prescribing of controlled substances. The regulation does not call for the use of urine drug screens until the prescribing has reached over three months. At that point, the regulation requires the physician to obtain a baseline urine drug screen and at random intervals as determined by the physician.

15. **Misconception:** A physician must conduct a complete physical exam for patients with psychiatric conditions prior to prescribing.

    **Fact:** The Board's regulation does not require a physician to conduct a comprehensive physical examination of a patient for psychiatric conditions. Instead, the physician should conduct the appropriate examination for these conditions.

16. **Misconception:** A long-term patient must be seen on a monthly basis to receive controlled substances from their physician.

    **Fact:** The Board's regulation does require the physician to personally see the patient at least monthly initially. However if the physician needs to prescribe controlled substances for longer than three months s/he may see the patient on a less frequent schedule after the physician determines:

    - the controlled substances prescribed have been titrated to an appropriate level to treat the medical complaint and symptoms;
    - the controlled substances are not causing harmful side effects; and
    - there is sufficient monitoring in place to ensure that the patient is not using the controlled substances inappropriately.

    It is important to for physicians to know that do not have to start from scratch or at ground zero for patients with whom they have been treating and have an established treatment routine. In these situations, the physician would simply need to resume adherence to the standards at the appropriate treatment level for that patient.

17. **Misconception:** Any physician's practice that has a majority of their patient population receiving controlled substances must register as a pain management clinic.

    **Fact:** Under the regulation, a practice does not become a "pain management facility" simply because half of its patients in any given 30-day period received a prescription for controlled substances. In order to establish that a particular practice was, in fact, a "pain management facility," the Board would also have to establish one or both of the following facts:

    a. a primary component of that practice was the treatment of pain; or
    b. the facility advertised in any medium for any type of pain management services.

18. **Misconception:** A physician must enter into a prescribing agreement with all patients receiving long-term controlled substances.

    **Fact:** The Board's regulation requires a patient to enter into a prescribing agreement only if the physician determines from screening that there is a significant likelihood that the patient may illegally divert controlled substances. Prescribing agreements are not necessary for patients determined to be low risk.

19. **Misconception:** The Board's prescribing regulation is overly burdensome and does not provide the physician with the flexibility in adhering to the standards.

    **Fact:** The Board's regulation does have provisions that provide flexibility to physicians where they cannot adhere to specific standards. In those situations, the physician would simply need to document the reasoning behind their decision. The Board is currently working on further clarification in the ordinary regulation.